

*CABINET POLICY: Insurance does not go into effect until the
Kentucky Volunteer Insurance Program has received premium.*

WORK RELEASE INSURANCE PROGRAM

2005-2006

Please furnish **ALL** information as requested below. Please **TYPE** or **PRINT**.

NAME: _____ PHONE #: _____
Last First M.I. Include area code

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
dd/mm/yyyy

ADDRESS: _____
Street City Zip

DESCRIPTION OF VOLUNTEER ACTIVITY: _____

VERIFICATION FROM SUPERVISOR: _____
Signature of Supervisor

_____ Title Phone #

BENEFICIARY OF THE INSURED:

NAME: _____

ADDRESS: _____

SOCIAL SECURITY #: _____

PHONE #: _____

	<i>Rate</i>
Accident:	\$ 54.00
Handling fee to cover the cost of processing: (postage, copying, membership fee, etc.)	\$ <u>6.00</u>
TOTAL AMOUNT ENCLOSED:	\$ <u>60.00</u>

Coverage will expire on June 30, 2006 regardless of the effective date. Fees will not be pro-rated for those applying during the year. **PLEASE DO NOT SEND CASH.** Make your check or money order payable to "Volunteer Insurance" and mail application to:

Kentucky Volunteer Insurance Program
KCCVS 3W-F
275 East Main Street
Frankfort, KY 40621

Please allow approximately two weeks for your application to be processed and a receipt mailed verifying your coverage.

Contact KCCVS at 800-239-7404 regarding coverage information.
E-mail address: kccvs@ky.gov

FOR OFFICE USE ONLY:

Receipt Date:

Signature:

Please feel free to copy this form and share it with volunteers who may not have received it.

